AUGUST 2001 RAI CONFERENCE Q & As
May 2002

GENERAL

5-1. Clarify the type/extent of MDS supporting documentation that is expected. Does the requirement for supporting documentation represent a change in policy from previous discussions of the MDS as a source document?

Documentation requirements have been addressed in Question 2-2 issued in March 2001. As explained in the Question 2-2, we do not require duplicate documentation solely for MDS reporting purposes. However, we have always maintained that facilities are expected to maintain sufficient documentation for care planning and on-going resident evaluation.

For example, good clinical practice has always dictated documentation of certain treatments and conditions such as the amount of IV nutrient intake and the number of minutes of therapy actually provided to an SNF resident. For these types of services, the more detailed documentation needed for good resident care also provides all the data needed to code the MDS. The MDS does not require duplication of the more detailed treatment logs; the data are simply summarized on the MDS. See Questions 3-34, 3-35 and 3-63 for documentation needed to assure quality care.

In addition, it is important to note that CMS does not impose specific documentation procedures on SNFs. Some facilities have developed tools to collect data across shifts or throughout an assessment period; e.g., ADL support needs, type and duration of restorative nursing services, etc. These tools may provide SNFs with more accurate data for MDS reporting and care planning, and may provide real value to the SNFs utilizing them. However, these tools are not mandated by CMS or by Fiscal Intermediaries.

When available, State agency and Fiscal Intermediary staff will utilize these data collection tools as part of an MDS validation review. In the absence of this type of documentation, the MDS can still be verified by a review of the entire record to verify that the medical record supports and is consistent with the responses on the MDS.

5-2. Will CMS develop an MDS for pediatric residents? Does the MDS adequately assess pediatric residents for reimbursement purposes?

We are considering the assessment needs of the pediatric resident in our MDS 3.0 development, and expect to develop MDS items specific to this population. At present, pediatric care represents a very small portion of the Medicare population, and has not been a primary focus area in our SNF PPS research. A number of state Medicaid programs with MDS-based payment systems have addressed this issue. Several states have developed special payment arrangements for pediatric care in SNFs; others calculate a RUG-III score in the same way they do for other SNFs.

5-3. What is the status of the post-acute assessment?

Special assessment needs of the short-term post-acute resident are being addressed in the MDS 3.0 development effort. The MDS 3.0 is currently planned for introduction in 2004.

5-4. Is there a time frame for implementing Section U?

Currently, we have no plans for implementing Section U.

5-5. What is the time line for revising the MDS Manual?

The revised manual is scheduled for release in summer of 2002.

5-6. Will you add a glossary to the MDS Manual?

We agree that a glossary is a good idea. We will see if it can be added to the MDS 2.0 Manual Update. If not, we will incorporate it into the MDS 3.0 manual.

5-7. Can an SNF resident refuse to have an MDS performed for religious or other reasons?

Yes. Any resident can refuse to have an MDS assessment. However, to be eligible for Medicare benefits, residents must authorize the release of necessary medical data. In the absence of the MDS, the resident may not be eligible for Medicare SNF benefits **beyond the default rate.** Staff should document the resident's refusal. Facilities that can show that the failure to complete an MDS was due to resident refusal will not be subject to a deficiency citation during survey.

5-8. What are the MDS requirements for facilities changing their certification status?

a. If a new facility is certified on July 1, 2001, do all OBRA and Medicare assessments need to be completed within 5 and 14 days from July 1, 2001? What date of entry should be used?

Nursing facilities must admit residents and operate in compliance with certification requirements before a survey can be conducted. The OBRA assessments are a condition of participation and should be performed *as if the beds were already certified.* Then, assuming a "clean" survey, the facility will be certified effective on the last day of the survey. If the facility completed the initial admission assessment prior to the certification date, there is no need to do another initial admission assessment. The facility simply continues the OBRA schedule using the actual admission date as Day 1. NOTE: Even in situations where the facility's certification date is delayed due to the need for a resurvey, the facility must continue performing OBRA assessments according to the original schedule.

Medicare cannot be billed for any care provided prior to the certification date. Therefore, the facility must use the certification date as Day 1 when establishing the Assessment Reference Date for the 5-day Medicare assessment.

b. What happens if the facility is not notified timely of its effective date for certification? Should the SNF have started the Medicare PPS assessment schedule prior to notification?

As indicated above, the SNF must establish the OBRA assessment schedule from the resident's date of admission. Assuming a "clean" survey, the SNF should implement the Medicare assessment schedule (for any resident in a bed that is pending certification) using the last day of the "clean" survey as Day 1.

5-9. What procedures should be followed if the SNF is already certified but is adding certified beds?

The procedure for changing the number of certified beds is different from that of the initial certification. Medicare and Medicaid residents should not be placed in a bed until you are notified that the bed has been certified.

5-10. How should SNFs continue the assessment schedule during a change in ownership situation? Does the assessment schedule change? Should the date of entry change?

There are two types of change in ownership transactions. The more common situation requires the new owner to assume the assets and liabilities of the prior owner. In this case, the assessment schedule for existing residents continues, but the facility uses the new provider number. For example, if the 14 day comprehensive assessment was done 10 days prior to the change in ownership, the next OBRA assessment would be due no later than 92 days from the R2b date of the 14 day assessment, and would be submitted using the new provider number. If the resident is in a Part A stay, the next regularly scheduled Medicare assessment would be the 30-day MDS, and would also be submitted under the new provider number.

There are situations where the new owner will not assume the assets and liabilities of the previous owner. In these cases, each resident is considered a new admission effective on the date of sale. New assessment schedules will be required for all residents in certified beds.

5-11. A resident is discharged with no expectation of return but does return within 15 months. Does the 15-month period for maintaining records apply to 2 separate admissions; i.e., does the record from the prior stay need to be retained in the current chart?

All facilities are required to maintain medical records on file for 15 months. In cases where the beneficiary returns to the facility after a long break in care (e.g., 14 1/2 months), staff may want to review the older record to familiarize themselves with the resident history and care needs. However, the decision on retaining the prior stay record in the current chart is a matter of facility policy rather than CMS requirements.

5-12. If a resident is transferred to a different facility, is the RAI/MDS transferred with the resident?

When transferring a resident, the transferring facility must provide the new facility with the resident's medical record, including any MDS assessments that were completed for that resident. However, when the second facility admits the resident, the MDS schedule starts from the beginning with an initial admission assessment and, if applicable, a 5-day Medicare assessment.

Section AA

5-13. Is Q&A #203 (from 8/96) still in effect with the advent of the new Attestation section at AA9?

No. This 1996 policy clarification was issued before the attestation policy was developed and has been superceded by the Attestation instructions.

Section A

5-14. (A3a.) What is the relationship between the Assessment Reference Date (ARD) and the completion date? Where is it documented?

Completion Dates

The MDS completion date (MDS Item R2b) is the date the MDS has been completed, reviewed and signed by an RN as complete. The completion for OBRA initial admission assessment is Day 14 of the stay with the admission day counted as Day 1. The Assessment Reference Date (MDS Item A3a) is the last day of the observation period. All assessments except for the initial admission assessment must be completed within 14 days after the ARD. For example, if the A3a date were set for December 8, then the latest completion date for this assessment would be December 22, (i.e., December 8 plus 14 days = December 22). Another way of looking at this is if the ARD is Day 1 then the completion date can be as late Day 15.

Observation Dates for ARD

Previously clarified in QA 22, August 1996, counting the days from the ARD to the look back timeframe for MDS items, you would count the ARD date as Day 1 and look back would be 6 more days to total 7 days for those MDS items with a 7-day observation timeframe. For example, for an annual assessment the ARD is set for May 27, the period of common observation for 7-day items is May 21 to May 27 and for 14-day items, the common observation period is May 14 to May 27. Both dates are inclusive in the count.

There has been some confusion about the definition of completion date, since this term is used differently when applied to Medicare Part A billing and payment. When preparing a Part A bill, the RUG-III payment rate may be adjusted on the ARD of a non-scheduled assessment; i.e., Significant Change in Status Assessment, Significant Correction of a Prior Full Assessment and Other Medicare Required Assessment (OMRA). In these situations, the ARD of the non-scheduled assessment is referred to as the completion date, and is used to indicate a change in the RUG-III group used for payment.

NEW POLICY EFFECTIVE JULY 1, 2002:

5-15. (A3a.) How should SNFs handle situations where the resident is discharged prior to the assessment reference date?

While it is clear that staff cannot assess a resident who is no longer in the facility, we have allowed facilities to transmit assessments without changing the Assessment Reference Date. In most cases, the assessment is being transmitted to support Medicare payment. However, we have encountered problems in our data analysis and reporting systems since the Assessment Reference

Date is later than the Discharge Date. For this reason, we have established the following standardized data collection and transmission procedure.

When residents are discharged prior to the end of the observation period, the Assessment Reference Date must be adjusted to equal the discharge date. We realize that adopting this policy results in a shortened observation period. For this reason, we have established two options providers may adopt to complete the assessment. These options are illustrated below using a 7-day observation period as an example.

Option 1 - Retain the truncated observation period and complete the MDS using less than a full observation period. In this case, if the Assessment Reference Date had been set at Day 5, and resident was discharged after 4 days of the observation period, the MDS would be completed using the data collected for the 4-day period in the facility and the 2-day period prior to admission.

Option 2 - Extend the observation period prior to the date of admission, and collect additional data to complete the assessment. Generally, this expanded observation period would require additional data from the prior hospital stay. In this example, if the resident was discharged after 4 days, the MDS would be completed using the data collected for the 4-day period in the facility and the 3-day period prior to admission.

Facilities must select one of these options and apply it consistently in all cases where the resident is discharged prior to the end of the observation period. It is not appropriate to change options on a case-by-case basis in order to increase reimbursement.

NOTE TO FACILITIES OPERATING UNDER AN OIG CORPORATE INTEGRITY AGREEMENT: OIG is aware of this policy change. If you operate a facility that has a Corporate Integrity Agreement (CIA) with the OIG and you have any questions, please call the OIG official responsible for monitoring the CIA.

5-16. (A3a.) When the resident is discharged prior to the completion of the observation period, and the Assessment Reference Date is adjusted, what date should be used to show the Completion Date at MDS Item R2b?

Use the actual date the MDS was completed, reviewed, and signed, even if it is after the resident's date of discharge.

5-17. What is the procedure if the resident goes on a home visit or therapeutic leave during a portion of the observation period?

The observation period may not be extended because a resident goes on a home visit or therapeutic leave during a portion of the observation period. If the Assessment Reference Date for an initial admission assessment is set at Day 14, and there is a 2-day temporary leave during the observation period, the two leave days are still considered part of the observation period. When collecting assessment information, you will not have data for 2 of the days in the observation period.

5-18. (A3a.) Page 2-7 of the RAI User's manual says if the resident is admitted to the hospital during the initial assessment period, the facility can continue the assessment or start a new one. Is this correct?

Yes, the resident has a choice. Facility staff may choose to complete the original initial admission assessment after a resident's return from a short hospital stay. In this case, the original Assessment Reference Date must be retained and staff must properly identify those MDS items that can be coded only when furnished during the nursing facility stay. For example, services such as therapy or doctor visits occurring during the resident's hospital stay would not be coded on the MDS. Your second choice would be to start a new assessment upon the resident's return. The facility would have 14 days from the return date to perform the initial admission assessment.

If the resident was in a Part A stay prior to the hospitalization, the facility will generally complete all or part of a 5-day Medicare assessment in order to establish a RUG-III group for payment purposes. Then, when the beneficiary returns, the facility will do a Medicare 5-day Readmission/Return assessment (MDS Item A8b=5). The Medicare Readmission/Return assessment may be combined with the OBRA initial admission assessment.

5-19. (A7.) How do you code the payment sources? Please explain each response item.

We recognize that many facility staff have had a lot of difficulty in reporting payment source. To a great extent, the problems are the result of lack of information; business office staff are more aware of secondary insurance coverage than clinical staff. For this reason, we are evaluating the usefulness of this item in our MDS 3.0 development. For now, please continue to use the definitions provided on pp. 3-32 of the MDS Manual. When evaluating the accuracy of MDS coding at a facility, errors in just the Payment Source item should not be heavily weighted. If the clinical coding and key identifiers are coded accurately, Payment Source errors should not be cited as evidence of inaccurate MDS processing.

5-20. (A7.) If the initial assessment was submitted showing Medicaid pending (or did not show any Medicaid eligibility), and the resident later becomes Medicaid-eligible with a retroactive effective date, should a correction be filed to replace the Medicaid-pending responses with the correct Medicaid information?

No. It is not a federal requirement to file a correction when you later determine that the resident's Medicaid effective date is different from what you initially reported. If your state utilizes the MDS for Medicaid payment, you may wish to contact your state agency to find out whether there are any applicable state requirements.

5-21. Is there a conflict between significant change definitions/descriptions on p. 2-8 of the manual and Q & A 185 from August Q & A's?

No. As discussed in the manual, clinical judgment is required to determine whether a significant change has occurred. The manual uses hip fracture as an example of a condition that could be considered as "transient" (which would not generally be considered a significant change), but that has such a major impact on the resident's functional status that it represents a significant change for that resident. Q-185 from August Q & A's makes the same point; i.e., that clinical judgment must be applied on a case-by-case basis.

5-22. Quarterly assessments can be done no later than 92 days from the R2b date of the last OBRA assessment. How early can the quarterly be done?

There is no policy specifying the earliest date on which a quarterly assessment can be conducted. However, during on-site reviews, surveyors should question any facility-wide patterns of early assessments to determine why they are being done so quickly. If, for example, the result of the early quarterly assessments were to misrepresent the Quality Indicator data, the facility's practice would be inappropriate. The facility may, in this instance, be cited for a deficiency.

5-23. Residents enrolling in a hospice program essentially meet the criteria for doing a significant change in status assessment (SCSA). Does this have an impact on coding A8a/A8b?

If the resident enrolls in a hospice (Medicare Hospice program or other structured hospice program), but remains a resident at your facility, an SCSA should be performed if you believe it to be appropriate. The SCSA would be coded in MDS Item A8a =3.

If the resident enrolls in the Medicare Hospice program, once Medicare hospice benefits are established, the beneficiary's care is no longer paid through the SNF PPS. MDS Item Aa8b, Medicare Reasons for Assessment, would be left blank. See Q 2-3, issued in March 2001, for additional information of performing SCSAs for residents with terminal conditions.

Medicare Reasons for Assessment

5-24. When is it appropriate to use grace days for a 14, 30, 60 or 90-day assessment?

While we expect facility staff to make every effort to perform the MDS assessments timely, we recognize that there will be occasions when a small number of assessments are done using the grace days. Some situations where delays in performing an assessment would be appropriate include absence/illness of the MDS Coordinator, reassignment of the MDS Coordinator to other duties for a short period of time, or an unusually large number of assessments due at approximately the same time. Grace days may also be used to more fully capture therapy minutes or other treatments. If, however, we identify an atypical pattern, such as grace days being used for all (or most) 14-day assessments, we would question whether the grace day process is being used correctly.

5-25. If I do a significant change in status outside a Medicare payment window, there is no code to check in A8b. Is a code required to show that the assessment should be used for Medicare payment?

At present, there is no way to show that the SCSA performed outside the assessment window is a Medicare PPS assessment. Until this problem can be corrected, code A8a =3 to show the SCSA, and A8b=8 to flag the record as a Medicare assessment. This procedure is an exception to the rule that OMRAs are performed only to show discontinuation of therapy for beneficiaries in RUG-III rehabilitation groups.

Discharges and Readmissions

5-26. For each of the 3 discharge codes, how should A8a and A8b be coded when the resident returns to the facility? How should AB1 (date of entry) be coded upon the return? What HIPPS codes should be used?

a. Reason for Discharge = 6, Return not Anticipated:

OBRA Assessments - If the resident returns, it is considered a new stay.

Date of Entry (MDS Item AB1): The Date of Admission changes to reflect the first day of the new stay, and a new initial admission assessment is required.

Medicare Assessments - The Medicare assessment schedule starts over with a 5-day Medicare assessment (A8b=1).

HIPPS Code - If the 5-day assessment is also the initial admission assessment, the HIPPS =11. If the 5-day PPS assessment is not the initial admission assessment, the HIPPS =01.

b. Reason for Discharge = 7, Return Anticipated:

OBRA Assessments - Complete a Reentry Tracking form, if appropriate. (See instructions for completing the Reentry Tracking form in the SOM). If the resident did not have a significant change, the original OBRA MDS schedule should be continued. If the resident has experienced a significant change in status, complete an SCSA upon the resident's return (A8a=3). Your next OBRA assessment will be due 92 days from the completion date of the SCSA.

Date of Entry (MDS Item AB1) - Retain the original date of admission in MDS Item AB1 and report the reentry date in MDS Item A4. The new start date for Medicare Part A coverage will be shown on the Part A bill the SNF sends to the Fiscal Intermediary.

Medicare Assessments - If the beneficiary was in a Part A stay prior to the hospital stay, complete a Readmission/Reentry Assessment (MDS Item A8b=5). The 5-day Readmission/Reentry assessment restarts the Medicare Assessment schedule. This 5 day Medicare assessment can be combined with an OBRA SCSA (A8a=3 and A8b=5) or can be prepared strictly for Medicare payment purposes (MDS Item A8a=00 and A8b-5).

If the beneficiary was NOT in a Part A stay prior to the hospital stay, complete a Medicare 5-day assessment (MDS Item A8b=1). Retain the original admission date (MDS Item AB1), and, for billing purposes, use the reentry date as Day 1 of the Medicare stay. The 5-day assessment starts the Medicare Assessment schedule, and can be combined with an OBRA SCSA (A8a=3 and A8b=1) or can be prepared strictly for Medicare payment purposes (MDS Item A8a=00 and A8b=1).

HIPPS Code - If the 5-day Readmission/Reentry assessment is combined with an OBRA SCSA (A8a=3 and A8b=5), the HIPPS code = 35. If the 5-day Readmission/Reentry assessment is prepared strictly for Medicare payment purposes (MDS Item A8a=00 and A8b-5), the HIPPS code = 05.

Reason for Discharge 8: Discharged Prior to Initial Admission Assessment

OBRA Assessments - This code (MDS Item A8a=8) is used whenever the resident is discharged prior to completing the initial admission assessment. This code is used even if a Medicare 5-day assessment has been completed. This code is also used regardless of whether you expect the resident to return. The OBRA initial admission assessment must be completed within 14 days of the reentry date.

Date of Entry (MDS Item AB1) - Retain the original date of entry. Enter the readmission/return date in MDS Item A4.

NOTE: The March 2001 Q & A's say that a reentry tracking record is not needed after a reason for discharge = 8.

Medicare Assessments - Generally, facilities complete Medicare assessments in order to establish a RUG-III group for payment. If the beneficiary had been in a Part A stay prior to the hospitalization, complete a Medicare Readmission/Reentry assessment. If the beneficiary was not in a Part A stay prior to the hospital stay, but returns with Part A eligibility, complete a 5-day Medicare Assessment, A8b = 1.

HIPPS Codes - If the beneficiary was in a Part A stay prior to the hospitalization, complete a Medicare Readmission/Reentry assessment (A8b=05). The HIPPS code will vary depending upon whether the 5-day assessment is combined with the initial admission. If A8a=1 and A8b = 5, the HIPPS code = 15. If A8a=00 and A8b=1, the HIPPS code = 05.

5-27. If the resident returns to the SNF after a hospital stay, do you need a new face sheet.

No. If the face sheet was transmitted prior to the hospital stay, and none of the information has changed, a new face sheet is not required. If you identify changes to the face sheet data, you should update it and transmit the revised face sheet with your next assessment.

5-28. Does an RAI assessment have to be done for a person admitted for Respite Care?

If the resident is in a certified bed, you must follow the OBRA assessment schedule. If the resident is in the facility for fewer than 14 days, no assessment is due. Since respite care services are not subject to a regular schedule, and the facility cannot predict a readmission/return with any degree of reliability, respite care residents should be discharged as Return Not Anticipated, MDS Item A8a=6. Also see Q 2-4 issued March 2001.

5-29. Some states cannot provide community care or waiver program benefits to nursing home residents. When a resident enters a nursing home for respite care, there may be a circumstance in which a client might require more than 14 days of respite care. Can the MDS requirements be waived in this situation?

No. If the resident is in a certified bed, the OBRA assessments must be completed.

5-30. If a beneficiary in a Part A stay is hospitalized and returns to the SNF without a significant change, but still eligible for Part A benefits, should the next PPS assessment be a 5-day or a Return/readmission?

If the beneficiary was in a Part A stay prior to the hospital stay, the facility should complete a 5-day Readmission/Return assessment, regardless of whether there was a significant change in the resident's condition.

5-31. Does the length of time the beneficiary is in the hospital change his/her status when readmitted to the SNF; i.e., is it considered a new admission if the hospital stay was longer than a certain number of days. For example, if the resident is hospitalized for one or two months, should the SNF submit a discharge tracking form?

We have not established a limit on the length of the hospital stay. The SNF must submit a discharge tracking form, even if staff anticipates a long period of hospitalization.

5-32. How is the MDS coded for a beneficiary who was discharged from Medicare Part A coverage and discharged from the facility, has a change in status within 30 days and again becomes eligible for Part A benefits under the same spell of illness. As a readmission/return showing the original date of entry in AB1? As a new admission? How should the start of the Medicare stay be coded for billing purposes?

Since the beneficiary was actually discharged either to home or to another facility, the discharge tracking record should have shown a discharge with no expectation of return (A8a=6). When the beneficiary returns, it starts a new admission. The date of admission for the second stay becomes the Date of Entry (AB1), and the OBRA and Medicare MDS schedules start from the new date of admission.

In this example, the admission date and the first day of Medicare Part A benefits are the same. It's important to remember that this is not always the case, since the effective date of Medicare coverage is not an MDS item. Medicare coverage information is always reported on the Part A claim.

5-33. A beneficiary was discharged from Medicare Part A coverage, but stayed in the facility in a certified bed. Services were reimbursed through another payer. The resident later has a change in status and again becomes eligible for Part A benefits under the same spell of illness. How is the MDS coded? As a readmission/return showing the original date of entry in AB1? How should the start of the Medicare stay be coded for billing purposes?

Since the resident stayed in a certified bed after Medicare benefits were discontinued, the facility must continue the OBRA schedule from the resident's original date of admission. There is no reason to change the OBRA schedule when Part A benefits resume.

When the Medicare Part A benefits resume, the Medicare MDS schedule starts again with a 5-day assessment, MDS Item A8b=1. The original date of entry (AB1) is retained. Since the resident has had a change in status, an SCSA must be completed with either the Medicare 5-day or 14-day assessment. The date Part A coverage was resumed will be shown on the Part A bill.

5-34. When a resident in a Medicare Part A stay is readmitted after a hospital stay and has had a significant change, should we do the significant change with the 5-day or 14-day assessment? How should the MDS be coded?

Since the beneficiary was in a Part A stay prior to the hospitalization, a reentry tracking form would be completed, and a readmission/return assessment must be completed. The Medicare reason for assessment in A8b is "5". If you have identified a significant change, and need to update/change the beneficiary's plan of care, you should combine this SNF PPS assessment with the comprehensive SCSA assessment.

In some situations, it may be appropriate to monitor the individual for a longer period of time to determine the specific care planning changes that are needed, and you may combine your SCSA with the SNF PPS 14-day assessment. The SCSA must always be completed within 14 days of identifying that the significant change has occurred.

5-35. After the initial admission (OBRA) assessment has been completed, a beneficiary in a Part A stay is admitted to the hospital for more than 24 hours. Upon return, a readmission/return assessment is required. How should it be coded?

Since the initial admission assessment has already been completed, you do not have to complete this OBRA assessment again. A reentry tracking form would be completed. If the resident returned to the SNF with a significant change, the primary reason for assessment in A8a is "3". If there was not a significant change, A8a should be coded "00". The Medicare reason for assessment in A8b is "5", since the beneficiary was in a Part A stay prior to the hospitalization and continues to be eligible for Part A coverage upon return.

5-36. Before the initial admission (OBRA) assessment has been completed, a beneficiary in a Part A stay is admitted to the hospital for more than 24 hours. Upon return, a readmission/return assessment is required. How should it be coded?

Since the initial admission assessment was not completed, the facility must complete a discharge tracking form with a reason for assessment of "8". In most cases, the facility will have completed a 5-day assessment covering the period from the date of admission to the earlier of the Assessment Reference Date (which can be assigned up through day 8 of the Part A stay) or the actual date of discharge. (See Q 5-15 for determining the ARD when the resident is discharged prior to the end of the assessment period.) This Medicare assessment will be needed to bill for Part A coverage.

Then, when the beneficiary returns, the facility completes the initial admission (OBRA) assessment within 14 days of the reentry date. In addition, the facility must complete a Medicare Readmission/Return assessment (coded A8b=5). The facility may combine the initial admission assessment (A8a=1) with either the Medicare Readmission/Return or Medicare 14-day assessment.

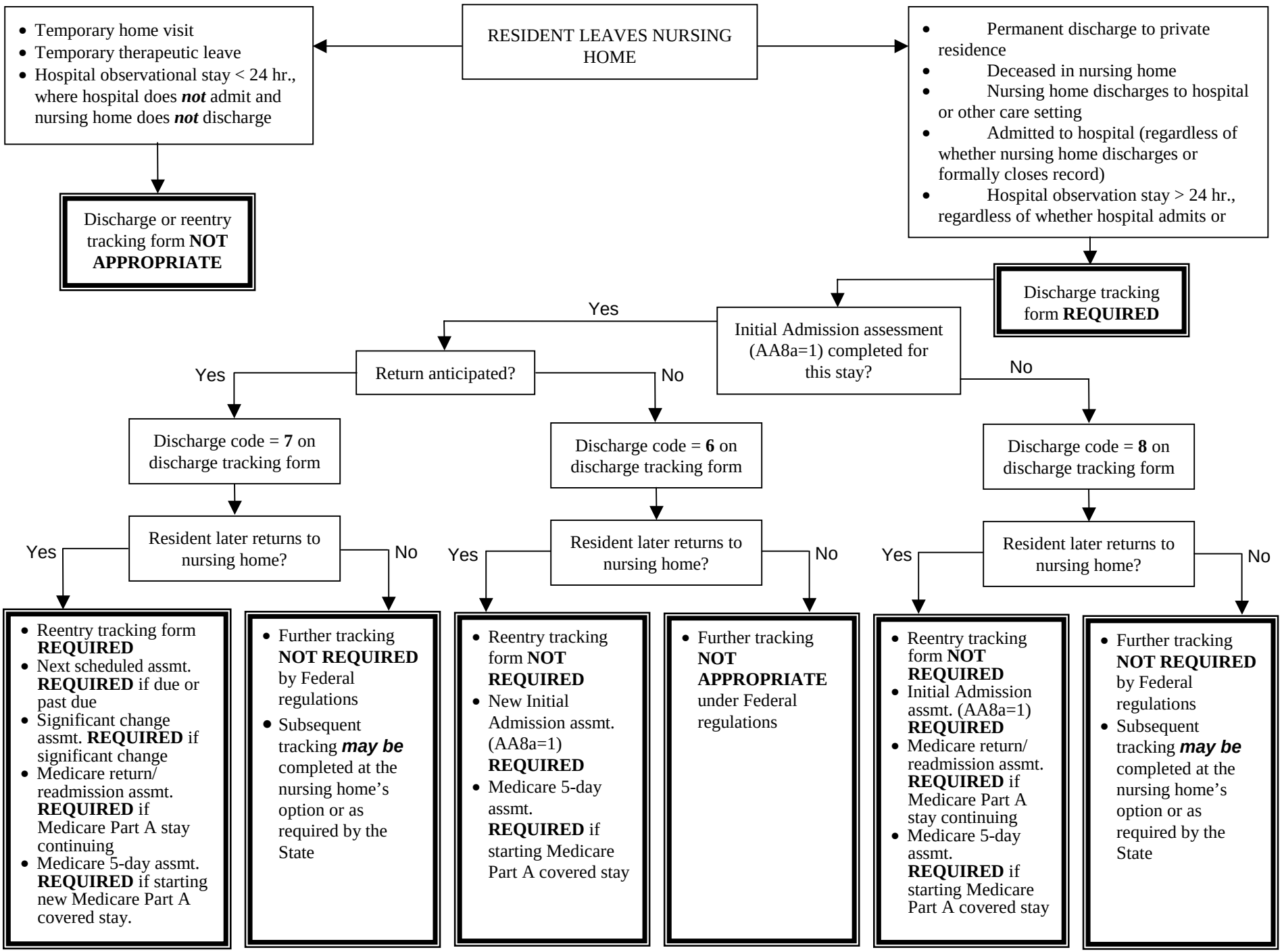
5-37. How should the MDS be coded for a Medicare beneficiary in a Part A stay who is out of the facility at midnight receiving hospital outpatient treatment, but who returns within 24 hours?

Since the beneficiary was out of the facility for less than 24 hours, it is not necessary to complete discharge and reentry tracking forms. This temporary absence does not require any change to the OBRA assessment schedule.

For Medicare billing purposes, the day ends at midnight. Medicare beneficiaries who are out of the facility at midnight are not eligible for Part A benefits for that day even though they have not been discharged from the SNF. However, this temporary absence for outpatient treatment does not require a Readmission/Return assessment.

Please note that the Medicare Assessment Window is calculated using Medicare-covered days. More detailed training materials are being prepared to explain how to calculate the Medicare assessment window in situations where the beneficiary has one or more non-covered days within a Part A stay. Please see the following matrix for more information on the discharge and reentry process.

MDS 2.0 DISCHARGE AND REENTRY FLOWCHART



Other Medicare-Required Assessments (OMRAs)

5-38. Is an OMRA required for a beneficiary who received some therapy but who was NOT classified into a RUG-III Rehabilitation group for SNF PPS reimbursement?

No. The purpose of the OMRA is to reflect a change from a RUG-III Rehabilitation group to a clinical payment group, and to discontinue the therapy add-on payment. If the resident is not in a RUG-III Rehabilitation group, it is not necessary to complete an OMRA. However, if the discontinuation of therapy represents a significant change, an SCSA is also required.

5-39. When a resident's therapy is discontinued, and we are scheduling the OMRA (due 8-10 days after the therapy services have ended), what is considered Day 1? The first day when therapy is not provided? The last day services are provided?

When preparing an OMRA, **Day 1** is the first day on which no therapy services were provided.

Change in Medicare Status

5-40. If a beneficiary in a Part A stay starts PT, does that restart the "Medicare clock"; i.e., is a new assessment required?

No. Adding therapy services to the treatments furnished to a beneficiary in a Part A stay does not automatically require a new assessment. However, if the therapy was added because the beneficiary experienced a significant change, an SCSA must be completed. In this case, the primary reason for assessment would be a significant change (A8a=3). If the SCSA is done during a Medicare assessment window, the SCSA can be combined with a regularly scheduled Medicare assessment. If the SCSA is not within a Medicare assessment window, the Medicare reason for assessment should be coded as A8b=8. See Q 5-25 for additional information on coding a SCSA that is not in an assessment window.

Section B

NEW POLICY EFFECTIVE JULY 1, 2002:

5-41. (B2a.) In coding short-term memory, should we be reporting the resident's highest level of function? For example, if a resident has a short-term memory (STM) problem 6 of 7 days, should we code a "0" to reflect the one day where short-term memory was okay? Conversely, if a resident has one STM test on day 1 of observation period and has no problem, do we need to continue assessing for the remaining 6 days of the observation period?

No. When coding short-term memory, we need to identify the most representative level of function, not the highest. Therefore, a resident with short-term memory problems 6 of the 7 days should be coded as "1". For many residents, performance varies. Staff must use clinical judgment to decide whether a single observation provides sufficient information on the resident's typical level of function.

Section E

5-42. (E1.) If an indicator of depression occurs twice in the last 30 days (not 2 times each week), should it be coded "1"? Or must the indicator of depression occur in each week (to be a "pattern") to be coded?

Yes, it should be coded as "1" to indicate that the indicator of depression was exhibited up to five days a week (but less than 6 days a week). It does not need to occur in each week to be coded.

5-43. (E1.) If an indicator of depression occurs only in the beginning of the 30-day period, is it correct to code E1=1 and E2=0 because of the change in observation periods?

Yes. E1=1 would indicate the indicator of depression occurred up to five days a week (but less than 6 days a week) in the last 30 days. E2=0 would indicate the indicator of depression had not occurred in the last 7 days.

5-44. (E1.) If a person is observed to have crying, but doesn't have sad or painful expression due to Parkinson's, is it necessary to capture those episodes if the reason is obvious? The manual instructions (3-58) say to code "irrespective of assumed cause".

To complete Item E1, staff must observe the resident for signs of verbal or non-verbal mood distress. If staff observes crying/tearfulness in the last 30 days irrespective of the cause, it should be coded on the MDS E1m accordingly. You are assessing what has occurred and has been observed. If the resident did not exhibit sad or painful expression, then it should be coded "0". It is inappropriate to assume that a resident with Parkinson's would also be exhibiting a "painful expression" if he/she had full control of the facial muscles.

Section G

NEW POLICY EFFECTIVE JULY 1, 2002:

5-45. (G1g.) How do you code residents who are independent, but do not wear street clothes; e.g., hospital based SNF residents in a hospital gown, residents in pajamas, etc? It's not accurate to code "activity did not occur".

We agree. The intent of the questions is to measure the resident's ability to perform activities of daily living - regardless of the type of clothing. Please code any clothing item, including items such as pajamas or hospital gowns. We will revise future forms to delete "street" from the question.

5-46. Are anti-embolism stockings considered street clothes?

No. Although anti-embolism stocking are not considered street clothes, they are included in the example related to Dressing, i.e., TED stockings, found on page 3-87 of the RAI Version 2.0 Manual. In future revisions to the MDS forms, "street" will be deleted.

5-47. (G1a.) Bed Mobility. If staff applies ½ side rails and then provides no further help, how is it coded?

Code as set-up help only.

5-48. (G1a.) Bed Mobility. Is it possible to have a score of "8/8" in bed mobility?

A bed mobility score of 8/8 will not result in an error message when the MDS record is transmitted. However, a score of 8/8 in bed mobility would indicate the activity was not performed by resident or staff (e. g., no one turned the resident). Generally, a more appropriate response would be 4/2-3; the resident was totally dependent on staff to perform the activity and required one or more staff members to assist.

5-49. (G1.) Bed Mobility. If the resident is coded as "3" in G1b, would you expect the care plan to note that the resident needs a 2 person assist?

CMS does not prescribe the level of detail in the care plan. However, the care plan should provide a template for the resident's care. It would certainly be reasonable and appropriate to list how many staff members it requires assisting a resident to furnish a new staff member with the information needed to provide safe and prudent care to the resident.

5-50. (G1.) Bathing. The facility has a policy that all residents are supervised when bathing; i.e., they are never left alone while in the bathroom for a bath or shower, regardless of resident capability. When we discussed the same type of supervision (i.e., required by facility policy) in terms of eating, we were told to code Staff support as 1 (Supervision) and Self Performance as 0 (Independence). Is this procedure to be followed for bathing supervision as well?

Yes. It is appropriate to code the Staff Support as supervision, even if the supervision is precautionary. In this particular example, the ADL coding is unlikely to misrepresent the resident's condition for either care planning or quality monitoring (QI) purposes. In addition, for the 4 ADLs used in the Medicare reimbursement system (bed mobility, transfers, eating and toilet use), payments do not change based on whether the resident requires supervision or is totally independent.

In reviewing the guidance for coding for Section G of the RAI User's Manual 2.0 on page 3-77, it states for **"**0" Independent – No staff help or staff oversight –OR- Staff help/oversight provided only one or two times during the last seven days. "1" Supervision – Oversight, encouragement, or cueing provided three or more times during the last seven days – OR – Supervision (3 or more times) plus physical assistance provided only one ore two times during the last seven days.

5-51. (G4.) Should the assessor check passive range of motion for all residents such as the cognitively impaired to make sure there are no limitations? The manual only says to check active range of motion.

The manual states code the appropriate response for the resident's active (or assisted passive) range of motion function during the past seven days. (p. 3-96)

5-52. (G4.) How do you code an amputation on the ADL section, Item G4 range of motion?

At the top of page 3-97, the manual details how to code amputations :1=for unilateral, 2=for bilateral & list the site.

5-53. (G1a.) If staff performed the activity for the resident during the entire observation period, does the activity have to be at full weight-bearing to be coded "3"? For example, how should we code a situation where the only thing the staff does is put on the resident's sock, but the resident can lift his/her feet to let the staff person put on the socks and shoes?

No, the activity does not have to be at full weight bearing to be coded as extensive assistance. For example, the coding example on page 3-87 instructs you to code a resident who is independent in dressing, except for TED stockings, as requiring extensive assistance; i.e., self performance =3 and staff support =2. The same coding should be used for assistance with shoes and socks.

5-54 (G6.) If G6b (Bed rails) is checked, should P4a or b (restraints) be checked any time a device is used (i.e., a device that is not considered a restraint by the facility)?

This issue was discussed at length in Questions 3-84 and 3-85, issued July 2001. To reiterate our response, staff must identify the use of a device and consider whether the effect of the device on the individual is to act as a restraint. If you determine that the device meets the definition of a physical restraint, it should be coded as a restraint.

<u>Section H</u>

5-55. Given that the 14-day time frame was established for adequate bowel assessment, do you have to assess voiding for 14 days when you can really establish voiding patterns in less time; i.e. the standard is usually 3 days?

Some people do use a shorter period of time. The 14-day period allows many opportunities for assessment.

5-56. People have lots of problems with the definition of fecal impaction; i.e., how to distinguish between merely constipation, hard stool or fecal impaction. If you do a digital exam and find hard stool, you're locked into a definition of fecal impaction. If you hadn't done the digital exam, and a later bowel movement or bowel regimen caused stool, would you consider the condition to be constipation rather than impaction? What kind of guidance should RAI coordinators be giving?

The distinction between constipation and fecal impaction has usually been the effort it takes for the resident to have a bowel movement. Most constipation will pass without manual extraction through the use of laxatives, enemas, high fiber diets, and other remedies. In constipated residents, many times just doing a digital exam will stimulate the bowel enough to move the stool.

On the other hand, fecal impaction usually requires a digital rectal exam to physically break the hard stool mass into smaller parts and remove them manually. Follow-up enemas may be given to move stool higher in the bowel. Residents with fecal impactions may present with other symptoms such as fever, acute abdomen (pain, cramping, swollen abdomen), nausea, vomiting, and thin watery discharge from the rectum (a sign liquid stool is passing around the hard mass of stool).

This issue is also addressed in Question 3-48 (July 2001) and Question 2-17 (March 2001).

Section I

5-57. The disease conditions in Section I require a physician diagnosis. For quadriplegia, is it sufficient to have a diagnosis of "spastic quadriplegia" (e.g., secondary to cerebral palsy) or "functional quadriplegia" (e.g. terminal Alzheimer's)?

No. There are narrative descriptions of each diagnosis in the MDS manual on p.3-111-113. Additionally, ICD-9 CM code ranges are provided for each of the disease conditions. With the information provided, neither of the examples provided would be accepted as quadriplegia. We plan to refine the disease section for the next revision of the instrument.

5-58. A resident has a diagnosis of Alzheimer's disease with depressive features. Should this be coded; i.e., just the depression diagnosis or as a stand-alone diagnosis?

When assessing a resident, it is essential to include what was observed and/or documented during a period of time as required per section and/or item of the MDS. If the resident with a diagnosis of Alzheimer's disease has expressions/features defined in the MDS on page 3-59 of Section E, Mood and Behavior Patterns, code accordingly. The resident's diagnosis of depression should have physician's documentation supporting the diagnosis. In addition, staff should address the resident's mood and behavior in the resident's record.

In situations such as this, always ask the resident's physician to provide clarification to assure proper coding of the disease or condition.

5-59. (I-3.) Can "conditions" be coded here such as a V code for colostomy, anti coagulation, etc?

V codes may be used if they affect the resident's current ADL status, mood and behavioral status, medical treatments, nursing monitoring, or risk of death (p.3-118).

Section J

5-60. (J5c.) What documentation is needed in the record to code a terminal condition?

A doctor's certification that the resident has six months or less to live must be present in the record before coding the resident as terminal on the MDS.

Section K

NEW POLICY EFFECTIVE JULY 1, 2002:

5-61. We have been instructed that chewing or swallowing problems should not be coded after special dietary or other modifications that allow the resident to consume food were implemented. The rationale was that there is no observed problem during the observation period. This answer seems incongruent when viewed with the answer for Q 2-24 (which specifically addresses a resident with dysphagia). The very fact that special modifications had to be designed and are still in use should indicate that the problem still exists.

We carefully considered the concerns raised during the recent RAI conference, and evaluated the impact of this policy on resident care. The fact that intervention is required to prevent/eliminate the chewing or swallowing problems is a strong argument for continued monitoring and periodic reevaluation of the effectiveness of the interventions. If the problem is omitted from the MDS, it is less likely that the underlying problems will be fully examined and addressed in care planning. By recognizing that successful interventions do not eliminate the underlying problem and reflecting those problems on the MDS, we believe we may achieve better resident outcomes.

Additionally, we recognize that a resident may have a feeding tube for augmenting nutrition in a resident who does not want to eat, although they have no swallowing problem and could take food by mouth. By allowing feeding tube and swallowing problem to both be coded, we will be able to provide more specific data.

For these reasons, we are revising our policy on coding MDS Item K1, Oral Problems. Effective July 1, 2002, staff should code chewing or swallowing problems on the MDS, even when interventions have been successfully introduced. This clarification supercedes all previous discussions of the issue including Questions 2-23 (March 2001) and 3-51 (July 2001).

Section M

5-62. Can you clarify how to code Section M?

M1 - **All skin ulcers** should be coded at M1. A skin ulcer is defined as a local loss of epidermis and variable levels of dermis and subcutaneous tissue. This open sore may develop because of injury, circulatory problems, pressure, or in association with other diseases such as syphilis.

M2 - Code **only pressure or stasis ulcers** here. You will have staged these ulcers in M1.

M3 - Code **all ulcers** resolved / cured / healed in the past 90 days.

M4 - Code ulcers if appropriate to their more specific description, i.e., abrasion, burn, skin tears or cuts.

M2 and M4 are subsets of M1.

Specific coding questions frequently raised deal with the following scenarios. A resident may have a combination of any of these, i.e., peritoneal dermatitis on a pressure point + peritoneal dermatitis not on a pressure point so that M1, M2 and M4d would all be coded.

	M1	M2	M3	M4 (x)
Red, no breakdown	X	X(1)		
Skin break any cause, no pressure	X			possiblyX (a or f)
Skin break any cause, on pressure point	X	X		
Rash - general				X (d)
Abraded area	X			X (a)
Peritoneal dermatitis, no pressure				X (d)
Peritoneal dermatitis, on pressure point	X	X		
Healed pressure ulcer			X	
Healed ulcer of any type			X	

5-63. Based on the verbal clarification that it should be coded only if pressure causes an ulcer, do Questions 3-60 and 3-61 need to be changed to "do not stage in M-1 unless pressure is the cause"?

As explained in Question 5-62, all ulcers should be staged in M1 regardless of cause. Questions 3-60 and 3-61 are correct.

5-64. What is the definition of an open lesion? Can you provide some examples?

Open lesions on the MDS instrument are described as skin problems other than ulcers, rashes, cuts, e.g. lesions such as cancer lesions. We omitted a definition for open lesions from the manual (p. 3-137) but will add it in future revisions.

5-65. If a person had erythema from strong urine on buttocks, and it resulted in skin breakdown assessed at Stages II and III, would you consider them pressure ulcers that were initiated by the skin's reaction to urine?

Yes, if the breakdown was over pressure points. See Q&A 3-58 & 3-62 from the July 2001 Q&As.

5-66. Some facilities are stating that if a lesion is caused by "shear", they do not consider this a pressure ulcer. It seems that shear can start the further breakdown of skin through pressure, after the initial insult to skin.

If not at a pressure point, the original skin shear could either be coded at M4a (abrasion) or M4f (skin tear). If the shear is at a pressure point it should be coded as a Stage II ulcer at M1b.

NEW POLICY EFFECTIVE JULY 1, 2002:

5-67. (M4.) I am concerned about the March 2001 Q & A 2-30 on coding a laceration that requires suturing or butterfly closure. You say code at M4g, but the RAI User's Manual specifically directs us to code a laceration at M4f.

Upon further review, we agree that lacerations should be coded as M4f regardless if they require suturing or butterfly closures or not. Question 2-30, issued March 2001, was in error, and has been superceded by this response.

5-68. What is the CMS position on the use of Iodophor gauze dressing on deep pressure ulcers? This product contains 0.67 betadine (iodine), and the company claims that it does not destroy healing or granulating tissue.

CMS does not take positions on clinical treatments or interventions. We would refer you to the clinical experts (e.g., physicians, pharmacists) for further information. The Agency for Healthcare Policy and Research (formerly AHCPR) has issued clinical practice guidelines for treatment of pressure sores. Pages 51 and 52 of this document (Wound Cleansing) recommend that ulcer wounds should NOT be cleaned with povidone iodine, iodophor, or hydrogen peroxide because these agents are cytotoxic to normal tissue. An accompanying table shows that Betadine Surgical Scrub would have to be diluted 1:10,000 to maintain white blood cell viability and phagocytic efficiency.

More details and full text document are at:
http://www.ngc.gov/VIEWS/summary.asp?guideline=8&summary_type=brief_summary&

Section N

5-69. (N2-1.) How do we evaluate time in activities for a resident who wanders and is cognitively impaired and exhibits behaviors?

Activities staff should work with cognitively impaired residents to identify what types of activities are suitable. Some impaired persons prefer to walk through the corridors rather than engaging in a seated activity. Based on the resident's activity plan, certain activities, although not structured, may still be considered activities. The MDS Coordinator should work with the activities staff to determine which behaviors are considered appropriate activities for engaging the resident.

For further clarification, please refer to Question 85 from August 1996 Q & As to pages 3-141 and 3-142 in the RAI user's manual.

Section O

5-70. (O3.) How are insulin pumps coded? The staff does not inject the resident; they fill and monitor the insulin pump.

There is no item for insulin pumps on the current MDS. You would code the MDS as follows:

O1 - Count the insulin as a medication
O2 - Identify if this was a new medication or not
O3 - Code **only** the number of days that the resident actually required a subcutaneous injection to restart the pump.

Also see Question 2-36 (March 2001).

Section P

5-71. (P1a.) Should items in P1a such as ventilators, IV meds, transfusions, and suctioning be coded on a 5-day or 14-day assessment if the services were provided prior to admission?

Items listed in P1a may be coded if they occurred within 14 days prior to the Assessment Reference Date, regardless of whether the services were provided prior to admission. **Do not code services that were provided solely in conjunction with a surgical procedure such as IV medications or ventilators.**

5-72. (**P1a.) Should C-PAP or Bi-PAP be coded as ventilators on the MDS**?

No. Please refer to Q 2-43 in the March 2001 Q & As.

5-73. (P1.) Is the 25% limit on group therapy calculated by discipline or in the aggregate? The CMS web site Q & A on "Reporting Rehab Therapy Minutes on the MDS" says to calculate based on total therapy minutes. The SNF PPS July 30, 1999 final rule (p. 41662, Column 1) says to count by discipline. Which is correct?

The 25% limit on group therapy should be calculated separately for each discipline.

5-74. (P1.) Should transepidermal wound stimulation (TEWS) treatment for wounds done in PT be counted as minutes in P1b?

When complex wound care procedures requiring the specialized skills of a licensed therapist are ordered by a physician, the wound care may be coded in Item P1b as physical therapy. However, routine wound care such as applying/changing dressings should not be coded as therapy. These services should be shown as wound care in Section M5g if the dressing is applied other than to feet or M6f if dressing is applied to feet.

5-75. (P3.) Is a progress note written by a nursing or restorative aide and countersigned by a licensed nurse sufficient to document the restorative nursing program?

In order to qualify as a restorative nursing program for MDS purposes, staff must document the nature of the deficit, the specific deficit and treatment goals, and the expected frequency and duration of treatment.; i.e., 20 minutes per day, 6 days a week. Once the purpose and objectives of treatment have been established, a progress note written by the restorative aide and countersigned by a licensed nurse is sufficient to document the restorative nursing program.

5-76. (P3.) Is it sufficient to mention, "maintain rehab program" on the Plan of Care to support the need for a restorative nursing program?

No. If a restorative nursing program is in place when a care plan is being revised, it is appropriate to reassess progress, goals and duration/frequency as part of the care planning process. Good clinical practice would indicate that the results of this "reassessment" should be documented in the record.

NEW POLICY EFFECTIVE JULY 1, 2002:

5-77. Can licensed therapists supervise aides performing restorative nursing services?

Generally, we expect licensed therapists to perform only those complex restorative services that require the specialized training and experience of the licensed professional. We do permit therapists to work with therapy aides and to report the minutes of aide care on the MDS in Section P1b when the aide is working within line of sight supervision of the licensed therapist. However, we generally expect therapists to discharge residents from therapy when the residents are ready to start a maintenance program.

Facilities may elect to have licensed professionals perform repetitive exercises and other maintenance treatments or to supervise aides performing these maintenance services. In these situations, the services may not be coded as therapy in item P1b since the specific interventions would be considered restorative nursing services when performed by nurses or aides. The therapist's time actually providing the maintenance service can be included when counting restorative nursing minutes. Although therapists may participate, members of the nursing staff are still responsible for overall coordination and supervision of restorative nursing programs.

5-78. (P3.) If a resident has been assessed to need particular nursing programs to maintain function (i.e., ambulation or ROM), and all the criteria on pages 3-154 through 3-156 are met, should the time spent providing these functions be coded in restorative nursing (P3)? Would maintenance be considered the highest practical function for this resident?

Yes. Generally, restorative nursing programs are started at the conclusion of a course of restorative therapy or when it has been determined that the resident has limited or no restorative potential. In this case, maintenance of existing function would be the highest practical level for this resident. Restorative nursing programs to maintain function would be appropriate.

5-79. If a resident is able to lift his arm up to a certain level, but needs some assistance to get the final stretch, is this considered active or passive range of motion?

Since the resident can participate in the exercise, it is considered active range of motion.

5-80. If a resident has multiple physicians; e.g., surgeon, cardiologist, internal medicine, etc., and they all visit and write orders on the same day, how should the MDS be coded? As one day with physician visits and physician orders? As one day and one order per physician?

The MDS item asks for the number of days – not the number of doctors or the number of different orders. If 4 doctors visited on the same day, and each doctor changed orders, the MDS must still be coded as 1 day during which a physician visited, and 1 day in which orders were changed.

5-81. Are all orders written on the day of admission/readmission considered "admission/readmission" orders? For example, one set are received in the AM, and further orders are given in the PM when the doctor visits the resident. Some facilities have argued that only the initial set of orders should be considered admission orders. Then, the second set of orders could be coded on the MDS.

The MDS asks for the number of days in which orders are changed, but specifically states that admission/readmission orders may not be considered order changes for MDS purposes. This prohibition against admission/readmission orders applies regardless of whether the orders are given at one time or are received at different times on the date of admission/readmission.

5-82. In some states, physicians may contract with pharmacist consultants to monitor and coordinate a resident's drug regimen. In this situation, the pharmacist may order medication changes. Can these pharmacist consultant orders be coded as physician orders on the MDS?

No. For MDS coding purposes, pharmacist orders may not be included. Page 3-161 of the manual specifically recognizes:

- MDs, DOs, podiatrists and dentists acting as either the primary or consulting physician;
- Physician assistants and nurse practitioners working in direct collaboration with the physician (does not include staff employed by the nursing facility).

5-83. Facilities are using side rails, but because they are enablers, the facilities are writing in "0" – not used. Is this correct?

While side rails may serve more than one function, the assessor should code P4a or P4b when the side rails meet the definition of a restraint. This does not preclude the assessor from also coding the device in Section G6b of the MDS if the side rails are also used for bed mobility or transfer.

5-84. Facilities consider MDS Item P4 as strictly a restraints item. Is this correct?

Yes. Follow the intent of this section when coding devices that restrain the resident.

5-85. Facilities seem to be using "low beds" for residents with a history of falls. Should this be coded as a device or restraint?

There is no category in P4 to code low beds.

5-86. Does CMS's current Questions & Answers regarding how to code the MDS Section P4 "Devices and Restraints", posted in July 2001, reverse coding instruction given in Question 123 that was posted in August 1996? How should this section be coded?

The intent of Section P4 in the RAI User's Manual is, "to record the frequency, over the past seven days, with which the resident was restrained by any devices listed below at any time during the day or night." The intent is followed by the definition of "physical restraint". The manual is the primary source of information providing people direction on how to code the MDS. CMS has posted Questions & Answers in an effort to clarify coding instructions. CMS is instructing those completing Section P4 of the MDS to follow the intent of the section and code items that meet the definition of a physical restraint. The intent is to code those devices listed in Section P4 that have the effect of restraining the resident. Disregard Question 123 posted in August 1996, and follow the intent given in the RAI User's Manual and subsequent information provided in the July 2001 release of Questions and Answers.

5-87. I'm concerned that people will take the concept of restraints being related to the resident's ability to move as a reason not to code trunk restraints.

One should be looking at a device and determining whether it meets the definition of a restraint. A physical restraint is "any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body." Freedom of movement is a primary aspect of the physical restraint definition as is the concept of normal access to one's body. A device that is attached to a resident's trunk will often meet one of these two criteria and thus meet the definition of a restraint.

5-88. If the resident exercises the right to use a restraining device although the facility does not see any medical necessity for the device and has informed the resident, should it still be coded as a restraint?

The law states that each resident has the right to be free from "any physical or chemical restraint imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms" (The Social Security Act - §1819(c)(1)(A)(ii)). CMS expects that no resident will be restrained for discipline or convenience. Prior to employing any restraint, the nursing home must perform a prescribed resident assessment to properly identify the resident's needs and the medical symptom the restraint is being employed to address. "While Federal regulations affirm the resident's right to participate in care planning and to refuse treatment, the regulations do not create the right for a resident, legal surrogate or representative to demand that the facility use specific medical intervention or treatment that the facility deems inappropriate. Statutory requirements hold the facility ultimately accountable for the resident's care and safety, including clinical decisions." Federal regulations do not require or prohibit the use of consent forms, nor do they allow for the use of consent forms to substitute the facility's responsibility to follow the regulations and guidelines mandating they provide appropriate care. According to the law, restraints can only be imposed to treat a resident's medical symptom, to ensure safety and only

upon the written order of a physician (except in emergency circumstances). So, a resident or his/her legal surrogate or representative may ask about restraints but cannot require that a restraint be used. The facility must evaluate the appropriateness of that request. "The legal surrogate or representative cannot give permission to use restraints for the sake of discipline or staff convenience or when the restraint is not necessary to treat the resident's medical symptoms. That is, the facility may not use restraints in violation of the regulation solely based on a legal surrogate or representative's request or approval (SOM, PP-46 and PP-47)."

5-89. Please clarify the use of chair and bed alarms. ***Example:*** **Resident placed in chair with chair alarm, resident stands up and attempts to ambulate and alarm sounds. Staff intervenes and places resident back in chair every time alarm signals. This seems to be restricting movement. Is this then considered a restraint?**

The alarm is not restricting the resident's freedom of movement. Unless the attachment of the alarm cannot be removed easily and restricts the resident's freedom of movement or normal access to one's body, the alarm device would not meet the definition of a restraint. In either case, there is not a category on the MDS 2.0 to code chair or bed alarms. The use of these devices should be documented on the medical record and in the care plan.

5-90. Where should chair or bed alarms be coded?

The chair or bed alarms are not coded on the MDS2.0. The use of these devices should be documented in the medical record and in the care plan.

5-91. For a cognitively impaired individual who does not acknowledge inability to rise, and makes attempts to do so, is the use of a device that prevents that (e.g., lap buddy, geri chair, etc) still coded as a restraint?

Yes. Cognitively impaired residents are at a higher risk of entrapment and injury or death caused by restraints. It is vital that restraints used on this population be carefully considered and monitored. In some cases the risk of using the device may be greater than the risk of not using the device.

5-92. How are water mattresses or "lipped beds" (i.e., raised sides in the mattress) captured on Section P when they are used to prevent the resident from getting out of bed?

There is no category in P4 to code "lipped beds".

<u>Section R</u>

5-94. Social Service staff is sometimes assigned to complete the mood/behavior sections of the MDS. They are often not trained to perform this type of assessment. What should the surveyor do?

The RAI User's Manual 2.0 provides guidance to the assessor for items in Section E Mood and Behavior Patterns. In addition, the manual indicates the following for each item: intent, definition, process and coding. However, we do not mandate a specific staff discipline or level of training for staff completing this section. Any staff member, including Social Service staff who are not specifically trained in this type of assessment, should consult with direct care staff over all shifts, and family members who have direct knowledge of the resident's mood/behavior.

5-95. In a large facility where the director of activities conducts facility-wide activities and activity aides do the actual work with residents, can the activity aide, with instruction from the director, fill out the MDS?

The nursing facility should have policies and procedures delineating appropriate professionals for assessing residents. On page 2-16 of the RAI User's manual states "facilities have flexibility in determining who should participate in the assessment process as long as it is accurately conducted. A facility may assign responsibility for completing the RAI to a number of qualified staff members. It is the facility's responsibility to ensure that all participants in the assessment process have the requisite knowledge to complete an accurate and comprehensive assessment." Activity aides may participate in the collection of data, but may not conduct the actual assessment.

Transmission & Reporting

5-96. What are the rules guiding transmission of MDS for residents who are not in Medicare or Medicaid-certified beds? Where can these regulations be found?

The law that governs the protection of a resident's right to privacy, via any vehicle, can be found in the Privacy Act of 1974. The Act specifically protects the confidentiality of personal identifiable information and safeguards against the misuse of the same. The Privacy Act can be found at www.usbr.gov/laws/privacy.html. The Regulation regarding a resident's privacy can be found in the Social Security Act at 1819(c)(1)(A)(iii) and (IV).

CMS has no authority to collect MDS records for residents who are not in a Medicare or Medicaid-certified bed. Those records are automatically rejected from the MDS standard system.

CMS created an MDS System of Records (SOR) that outlines the guidelines specified in the Privacy Act. The MDS SOR has recently been updated to include MDS assessments in swing bed hospitals, and can be found in the Federal Register Vol. 67, No.30, Wednesday, February 13, 2002.

5-97. What are the CMS SUB-REC requirements and how should we use them?

CMS implemented a new field titled SUB-REQ (submission requirement) into the MDS 2.0. This system change requires facilities to identify Federal, State or No authority to collect resident's MDS information by choosing the appropriate number:

3. Federal Authority to collect MDS information for all residents residing on a certified unit.
2. State Authority to collect information under state licensure or Medicaid requirements.
1. No Authority to collect

It is the facility's responsibility to determine that appropriate authority is present before submission. You may contact your State RAI Coordinator who can tell you if authority to collect exists in your state. A list of RAI Coordinators can be found at www.hcfa.gov/medicaid/mds20/state.html.

For further instructions/clarification regarding SUB-REQ requirements, you may go to our website at hcfa.gov/medicaid/mds20/mdssoftw.html.

5-98. Some managed care companies require MDS completion (as if the resident was a regular Medicare beneficiary). Should facilities transmit these MDS assessments?

CMS has the authority to collect data for any resident in a Medicare or Medicaid certified bed. This authority applies regardless of payer source or type of assessment being performed; i.e., OBRA, Medicare PPS, other payer, facility policy. Therefore, as long as the resident is in a certified bed, the facility may transmit and CMS may accept MDS records.

Corrections

5-99. Is there a penalty for submitting too many corrections?

No. However, facilities exhibiting a pattern of multiple corrections may be subject to stringent MDS review during survey. If the surveyor identifies an error pattern impacting Medicare or Medicaid reimbursement, we would expect the survey agency to alert the FI or state Medicaid agency of the problem.

5-100. Are SNFs required to submit corrections every time an MDS error is identified?

No. However, there are consequences to facilities resulting from the use of inaccurate data including QI flags, survey citations, and penalties that may be imposed related to the attestation language. Authority for consequences of recognized errors is cited in the CFR at Section 483.20(j) and (i) and (ii). These sections address the issue of willingly and knowingly submitting inaccurate information in a resident assessment and the possible ramifications of that decision if the facility chooses not to correct. The law can be found in the Social Security Act at 1819(B)(i)(ii)(I)(II)(III).

Additionally, 483.20(g) requires providers to submit assessments that accurately reflect a resident's status. It would be prudent for any provider, given the potential penalties that could result if data are inaccurate, to correct the errors.

Care Planning

5-101. If the plan of care addresses the lowest function, it will not reflect the MDS assessment. Will this discrepancy be taken into account when verifying the MDS through use of supporting documentation?

The plan of care should present a true picture of the resident's status. It should therefore be revised with any major change of condition (good or bad) as well as when completing a significant change assessment (p. 2-8 through 11). If staff document in accordance with clinical practice standards, there should be sufficient documentation in the record to verify the MDS.

5-102. Should every item that triggers be included on the care plan?

No. After using the RAP Guidelines to assess the resident, the staff may decide that a triggered condition does not affect the resident's functioning or well-being and therefore should not be addressed on the care plan (p. 5-3).

Payment

5-103. Where can you get a Medicare payment manual?

Medicare manuals and Program Memoranda can be downloaded from our web site: www.hcfa.gov/pubforms/progman.htm.

5-104. Are resident name and Medicare number matched on the MDS for Medicare claims processing? If the name doesn't match the SSA record, will any one notice?

Yes. CMS has established several systems to match MDS and claims data. CMS's Data Analysis and Verification (DAVE) contractor is developing methods to identify provider patterns suggesting incorrect billing or program abuse.

5-105. How should an SNF bill if the assessment was completed timely, but was not submitted timely? Using the RUG-III rate determined from the assessment? At the default rate?

At the present time, we are not applying claims processing penalties on providers who are completing the MDS in a timely manner, but who transmit the data late. The claims should be billed at the RUG-III rate for the assessment that was completed timely.